Trauma Exposure, PTSD and Violence 5
Written Video Transcript

What about the vets? Let's turn our attention to those three studies that I said that I wanted to bring in to talk about PTSD vets, the three Gs as applied to the vets. [00:00.20.00] This study was done very recently by Dr. Freeman and his associates at the VA in Little Rock where they compared participants in their inpatient PTSD program with hospitalized homeless vets. And really there was no comparison between the [00:00.40.00] two groups in terms of attitude—gun ownership rates, very high in the PTSD program patients, quite low in the homeless population, lots of differences in terms of attitudes about the use of guns. And then some pretty disturbing statistics here. [00:01.00.00] High rates of those in the PTSD program who had guns holding a loaded gun with suicide in mind, aiming a gun at a family member, patrolling their property with a loaded gun, actually firing the weapon inside the walls of their own home. [00:01.20.00] Many of them had been asked by family members and mental health professionals to get rid of their guns. Hadn't done it but they'd been asked. That's very recent information from a study done at the VA in Little Rock. They've done it twice now. They reported similar findings about four years ago. [00:01.40.00] And we may be doing something like this, a similar set of studies at Menlo Park because the evidence here is that many PTSD combat vets own weapons. And these are not hunting weapons. They [00:02.00.00] may have some hunting weapons but they've also got assault weapons and handguns, concealed handguns. Taking a look at the one study that I found in recent PTSD vet studies [00:02.20.00] that actually looked at incarcerated vets, vets who were incarcerated because they committed violent offenses. And what this study did, this was done by (Saxon, et. al) that's the [2:34] (Braskin) group up in Seattle, what they did was compare[00:02.40.00] —they first diagnosed PTSD or not in the incarcerated sample and then compared the PTSD positives with the PTSD negatives in terms of the severity of their traumatic experiences, [00:03.00.00] how serious their violence was, how serious their use of alcohol and other drugs—primarily cocaine and heroin were—and co-morbidity, the presence of early psychiatric symptoms. And you can guess it. Each one of these things are significantly different and higher for the PTSD positive vets [00:03.20.00] than with the incarcerated but PTSD negative vets. The third study that I wanted to talk about actually looks at PTSD [00:03.40.00] vets in the Seattle inpatient treatment program, looks within the sample there around these issues and then looks—compares that hospitalized group with another non-PTSD hospitalized group against the National Vietnam Readjustment Survey [00:04.00.00] community sample group. So, that'll be what the second slide is about. But let's look at this one first here. Within the group of PTSD vets at Seattle those who were reporting more violence also had higher [00:04.20.00] combat exposures, specifically, in this one right here. And this didn't mean necessarily perpetrating war zone atrocities so much as being where they were being perpetrated, having your unit engaged in it whether you were a participant or an observer. There wasn't that much difference [00:04.40.00] in terms of the actual role.

It was the exposure to that kind of activity in the war zone that distinguished the higher violent PTSD positives than from the lower ones, higher co-morbid rates of depression and substance abuse. Getting the picture here? The guns, gangs and gin thing [00:05.00.00] with the vets? Another substance abuse difference, more immediate use before—immediate before a mission. And if you take—taking psychoactive meds as an indication of more serious co-morbidity [00:05.20.00] then you have this as distinguishing those who are higher in violent activity than the lower violence group. So that's within the group of PTSD positives there. Let's, well let's look within the juvenile offender [00:05.40.00] group in terms of some correlates of PTSD as well. And if you look at the bottom here we'll get to the bottom line. There is a medium-sized correlation between the number of violent crimes that were reported by the incarcerated adolescents and the severity of their PTSD. [00:06.00.00] It's also true, as you might expect, that PTSD was moderately correlated with each of the forms of traumatic exposure with the exception of current dating violence. Depression pretty much mirrors the same pattern but depression itself was not [00:06.20.00] related to either the number of violent or non-violent crimes. Another way of looking at that same relationship within the adolescent offenders is to look at the PTSD [00:06.40.00] severity sorted across the number of individuals who had no violent offenses, just one, two, or three or more. And you can see a nice staircase kind of relationship there showing a (dose) response kind of relationship between PTSD severity and proclivity for violence, the [00:07.00.00] number of violent crimes reported. I think I have the other—yeah this is the same kind of relationship here with the (McFall) data comparing the Seattle inpatient PTSD positives in terms of violent activity reported in the last four months [00:07.20.00] with the PTSD positives in the community in the VRS sample versus the non-PTSD psychiatric patients. Essentially showing that it's not just violence exposure it's also PTSD, probably in combination, that increase risk [00:07.40.00] for violence in both the adolescent offenders, the at-risk adolescents as well as the—in the three studies here that we've looked at with combat vets. So, to summarize—and I've written the summary specifically [00:08.00.00] for the adolescents and leave it to you to think about whether you would want to generalize the findings from the adolescents to the studies that we've looked at on combat PTSD vets. What are our trends here? Lots of family conflict and very few intact families. [00:08.20.00] Punishment is prevalent and illegal behavior is modeled just like in the classic longitudinal studies. Families that don't have protective factors, poor parental monitoring, poor perception of family support [00:08.40.00] and the early use of marijuana and alcohol to make it, so to speak. Birds of a feather, friends and family members who are also using alcohol and drugs. [00:09.00.00] Severe exposure to life-threatening forms of community violence and family violence. Multiple traumatic experiences, usually by the time they're 13 or 14 years old. All of which—remember the other slide?—all of which contributed to PTSD. High levels of depression and grief—[00:09.20.00] remember the number of friends that they'd seen killed and family members that had been killed?—and negative expectations about the future. Makes sense then to be concerned about the here and now doesn't it and to live life as full as you can in the short term. Well, how can you do that? Gang involvement, [00:09.40.00] substance abuse, gun possession. So, in terms of clinical implications for at-risk adolescents, perhaps for the combat—some of them for the combat vets [00:10.00.00] as

well, I'm sad to say that at the time we did the studies in the probation camps in Los Angeles there was no systematic mental health evaluation being done on children as they were brought into those facilities. [00:10.20.00] That was true five to ten years ago. It is not true now. I'm happy to say that there are systematic efforts underway to identify the psychological needs of children as they come into incarceration. [00:10.40.00] High rates of PTSD of 30% to 40% of the males and 50% to 60% of the females who are incarcerated have PTSD and co-morbid depression and almost universal substance abuse. Wouldn't it make sense to do something about that during the five to six months that they're going to be incarcerated? [00:11.00.00] We have said this time and time again to the authorities down in Los Angeles county, that these things are very predictable in the population of children that arrive at those camps and that as a minimum 12-step groups [00:11.20.00] could be established to at least provide an alternative to just the PE and school that's the main form of intervention that goes on in those probation camps. There's some variation across the camps. There are 13 of them for males and four or five of them for females and they're not all the same. [00:11.40.00] Some of them are much more psychologically minded and interested in rehabilitation than others. Some of them are just near boot camps. Relapse prevention. Remember the question about, "Were you carrying a gun when you came in and [00:12.00.00] do you plan to continue to carry a gun when you leave here?" I mean you can do some simple screening here. Simple screening to identify those on the basis of their own stated intentions as members of high risk groups that could then be targeted to actually [00:12.20.00] do something about reducing risk for engaging in these three risk activities. Gang involvement. Over 90% of the males and 70% of the females [00:12.40.00] were heavily involved in gangs at the time they responded to our interview in the study. Heavy, heavy involvement in gang activity. Very few of them joined gangs to actually get [00:13.00.00] victimized, you know. If you ask them about why they joined gangs it was the same reason they gave for carrying guns. "I live in an unsafe neighborhood. You know, I get picked on by rival gangs getting to and from school. [00:13.20.00] I got jumped into my local gang because I was being picked on." Many of them also came from families where family members, particularly uncles or cousins, sometimes fathers, in a few cases mothers, had been gang members in their adolescence. [00:13.40.00] So, they came by it two ways. Made sense in the immediate context of the environment that they lived in for protection and it was a family tradition. The gin part. Remember my story about making it through boring classes or [00:14.00.00] anxiety, treating anxiety about what you're going to face when you get home and using marijuana because it's readily available to do that? And then partying with the gang with alcohol and cocaine. [00:14.20.00] A pattern of drug use that we see repeated. And many of these children know they have problems with drugs. It's not a matter of arguing with them about whether the level of use that they're engaging in is going—has already caused them problems. If you ask about adverse consequences many of them will report getting into fights, [00:14.40.00] ditching school, doing poorly at school, interpersonal problems with a girlfriend or boyfriend or parents, trouble with the law and so on. The consequences that you see with adult-age veterans are the same consequences in terms of the alcohol and drug abuse [00:15.00.00] that you see with the adolescents. The gun part. And I know many of you deal with veterans who will tell you that the last thing that they're going to do is discuss with you their constitutional right

[00:15.20.00] to own a firearm. So, I'm not going there, you know? I'm not going to go there. What we can do though is use a motivational approach to examine the consequences, the possible consequences pro and con, [00:15.40.00] of continuing to use firearms in the way that you have them, the way that you store them, where you keep your ammunition, when you keep them on your person. In particular, what you do to change the way that you access them as a function of being emotionally upset, [00:16.00.00] particularly angry at self or others, and secondly, when you're drinking. The two drugs that are most likely to be involved in aggression are what?

[16:16]

Alcohol and =

(Marijuana.)

= cocaine. Or some [00:16.20.00] stimulant. Now, we might wish that they were using marijuana at a time like that. So, rather than try and get into a contest with these adolescents or with our veteran patients about their right to have guns or their need for them [00:16.40.00] we can talk about the pros and cons. Some of the places that the—remember we had money and we could ask the adolescents quite a number of questions about each of these risk areas and we did. Where did they carry their guns? It was really scary folks to get the answer to that question. "When I'm kicking it [00:17.00.00] at the mall. When I'm driving in the car. When I'm at a party. That's when I'm carrying—I'm packing." Well, the car part really got my attention 'cause I share the road [00:17.20.00] with a lot of those children. And sometimes their driving behavior disturbs me. But I need to remember, I need to remember what may be in that other vehicle and what alcohol or drugs may be on board the driver [00:17.40.00] or others in that car and what weaponry may be as part of that. So, the gun thing, that's a delicate, a delicate issue but one nevertheless that I bring up because it's a risk factor. [00:18.00.00] It's a risk factor. Do you suppose that two-thirds of these adolescents who are incarcerated who'd been shot, the males, and survived it this time, do you think that's going to be the end of it? Because, you know, remember the data [00:18.20.00] that virtually half of them who'd been carrying weapons before said that they were going to continue to carry. The single most risky thing you can do in terms of having a weapon used on you is to be known to be carrying a weapon. So, there's some things [00:18.40.00] that we can do, not about their choices, you know, or arguing about who's right and who's wrong about the issue of gun ownership or gun access but about the consequences of the choice that's made. If you make a choice to carry then what's likely to happen? What do you increase the risk of? If you make a choice not to then [00:19.00.00] what do you have to deal with in order to implement that choice? And the same thing could be said for each of these other major risk factors. For our veterans it's not so much that they're involved in gangs so much as they're living in unsafe neighborhoods, many of them, where there are risks [00:19.20.00] attendant in the neighborhoods or communities where they live that put them in a place where they think that they need a weapon. And, you know, objectively it may well be that police protection in many at-risk neighborhoods is not what it should be

and that in many cases citizens [00:19.40.00] may feel justified in making a decision to take care of their own safety by having firearms and keeping them loaded and so on. But you know, again, with our veterans there are risks to that. I know there are probably more veterans that have shot themselves in managing their weapons. [00:20.00.00] Amongst the people I know who have firearms I know two people who shot themselves in the leg or other places down there that, you know, it wasn't an altercation. It was normal maintenance of their weapons. And these were careful people and as far as I know they weren't drinking when they were doing that. So there are risks [00:20.20.00] associated with having loaded weapons and doing the things that one does in service of that. What I'd say about the gin thing and I think this—I would hold this out as being applicable both for the at-risk adolescents as well as [00:20.40.00] the vets that you work with. There is a price paid to use psychoactive substances to deal with stress and sometimes it may seem like [00:21.00.00] it's worth it. I have a hard time convincing myself that a battered woman who uses alcohol to get to sleep at night when she's too terrified to sleep otherwise, who's got children dependent on her and needs to function the next day, to use alcohol or other psychoactive drugs in order [00:21.20.00] to accomplish that form of coping in order to continue to function, I have a hard time calling that abuse. Because it seems like the best coping that can be done under those circumstances perhaps for someone with very limited prospect. And I think you can make the same [00:21.40.00] argument here for many of these adolescents who have really not much positive to look forward to in their home environments or in their community environments. And in that way alcohol and drug use can look like a reasonable way to cope with those problems. But the consequence you well know and I think [00:22.00.00] many of them know, they've already started to accrue adverse consequences. It's not like these things happen years or way down the line. It's that the more that you do it the more the likely these consequences are going to happen to you now and not later. And there are other alternatives. [00:22.20.00] Twelve-step programs are everywhere, and it's not just for alcohol. There are 12-step programs for all kinds of psychoactive drugs and other kinds of addictive activities. And our—whenever we've talked to the probation camp authorities in Los Angeles about things that they can do that won't cost a lot of money, [00:22.40.00] inviting 12-step groups, different 12-step groups to come and have meetings, to offer space for meetings and to allow the residents to participate in those and to hear the stories of people who've had problems, [00:23.00.00] the same problems that those kids are having, who are at a different place in terms of their recovery is probably a minimal effort that doesn't cost the county of Los Angeles very much but might well benefit many of the children who are already showing signs of addiction to alcohol or other drugs. [00:23.20.00] To the extent that we need to be more interactive in linking up with community-based resources in our PTSD programs, our programs for vets in the VA, I think the same thing might be said. It doesn't cost us [00:23.40.00] much to invite 12-step programs to sponsor meetings on our premises.

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